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DEPARTMENT OF
FAMILY MEDICINE

DALHOUSIE UNIVERSITY
HALIFAX, N.S.

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November 17, 1982

Dr. R. Colin D. Stewart, M.L.A.
Chairman
Royal Commission on Health
P. O. Box 488
Halifax, N. S. B3J 2R8

Dear Dr. Stewart:

Enclosed please find a submission for the Royal Commission on Health which is presented on behalf of:

The Department of Family Medicine - Dr. Brian Hennen, Head
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The General Practice Section of - Dr. Paul MacLean, Head
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We have the opportunity of presenting this verbally at 3:30 p.m. on November 30th.

Yours truly,

Brian K. E. Hennen, M.D.
Professor and Head
Department of Family Medicine

BKEH:cs
Encls.
c.c. Dr. P. MacLean
Dr. D. Zitner
Dr. R. L. Brown

PRIMARY HEALTH CARE IN NOVA SCOTIA

A SUBMISSION TO THE
ROYAL COMMISSION ON HEALTH CARE
FOR THE PROVINCE OF NOVA SCOTIA

BY

THE DEPARTMENT OF FAMILY MEDICINE
DALHOUSIE UNIVERSITY

THE GENERAL PRACTICE SECTION OF
THE NOVA SCOTIA MEDICAL SOCIETY

THE NOVA SCOTIA CHAPTER OF THE
COLLEGE OF FAMILY PHYSICIANS

THE HALIFAX GENERAL PRACTITIONERS' SOCIETY

INTRODUCTION

The family doctors of Nova Scotia welcome the opportunity to express to this Commission their concerns for the future of primary health care in Nova Scotia.

These concerns relate to: education for family doctors; home care; preventive practices; the availability of services; and continuity of services. Particular medical disciplines which are part of primary care are addressed with particular concern for geriatrics as well as for aspects of pediatrics, obstetrics/gynecology and psychiatry.

I EDUCATION OF FAMILY DOCTORS

a) The Problem - Discontinuance of Nova Scotia's payment for Family Medicine Residencies.

The Dalhousie Department of Family Medicine has been informed by letter (October 27, 1982) from the Deputy Minister of Health that the Department of Health of Nova Scotia will no longer provide funding for residency salaries in Family Medicine. "I must tell you that we are forced to prioritize the specialties we can support financially and Family Medicine is at the bottom of the list."

When other Canadian provinces are increasing their residency positions for Family Medicine, the Nova Scotia government has decided to discontinue its funding for Family Medicine residencies altogether. Even in the face of overall cutbacks in internships and residencies, Ontario, by comparison, is increasing its allocation of positions for Family Medicine.

Canada has been a world leader in educating family doctors. The College of Family Physicians of Canada together with all sixteen Canadian medical schools have developed residency training programs since 1966.

b) What Family Medicine Residencies Offer.

Family Medicine Residency Training offers two years of clinical education specifically designed to prepare graduates to provide primary care as family doctors with experience and education for practicing in the community as well as in hospital. Programs emphasize office practice, preventive care, expanded interpersonal skills, home care, and continuity of patient care.

For example, during a sixteen week assignment (there are 96 training weeks in the whole program) in the Halifax Family Medicine Centres,

a second year resident (in the office for 18 hours each week) will conduct some 420 office consultations, conduct 25 pre-natal visits, deliver 2 or 3 patients, will be on-call every fifth night, make house calls, make 30-40 visits to patients in nursing homes, visit some 30 patients in the Emergency Rooms and make some 25 visits to patients in hospital. As well, he/she will participate in 208 hours of formal seminar programs on common problems in family practice; interviewing skills; practice management; counselling for psycho-social problems such as marital or family disruption; and special topics such as alcoholism, screening, the early recognition of disease, and child battering. The resident will attend Journal Club every two weeks, will sit on at least one monthly committee of the Department, is expected to teach Third and Fourth Year medical students and family practice interns, prepare three formal seminars and complete a research project. This is a heavy work load for a young practitioner in a concentrated learning environment.

c) Other Training in Family Practice

The Canadian Medical Association General Council 1981 Medical Education Report in discussing training for general practice, stated, "Experience in continuity of patient care is more difficult to implement. Family Practice residencies have achieved this to a greater extent than have other postgraduate training programs." The rotating internship, the usual alternative clinical education, which is the minimum required for licensure in all provinces except Alberta, is in comparison, one year long and takes place entirely in hospital with the only ambulatory or office-like learning experiences being in hospital Emergency Rooms or Out-Patient Departments.

In the United States, Family Medicine Training programs are three years long and in the United Kingdom, three years of vocational training are required for a general practitioner to operate as a principal (independent practitioner) in the National Health Service. Australia has a five year training program. Most other Western countries are developing specific postgraduate education programs for Family Practice.

Graduates of Canadian Family Medicine Residency Programs are eligible to write a certification exam of the College of Family Physicians. More than half of those who have passed the exam have come from residency training programs.

d) Dalhousie Family Medicine Residency

Dalhousie University has had a residency training program in Family Medicine since 1969. As of June 1982, 107 graduates from the program have taken the certification exam and 104 (97.2%) have passed. The national pass rate of residency trained candidates in the history of the exam is 88% and for non-residency trained candidates is 75%. A comparative review of the 1980 exam showed that Dalhousie residents performed first of sixteen medical schools on two of the three main components and second on the remaining component. In 1982, all thirteen Dalhousie candidates were successful with an average performance 10% above the national average on all three exam components.

Medical school transcripts show that applicants accepted into the program over the past five years have been, as a group, above average in academic performance.

It is clear that this program is one of high standards and does not cater to slow learners or less confident graduates. The Dalhousie Family Medicine Residency Program is highly regarded nationally.

e) Effects of Nova Scotia Withdrawing Residents' Salary Support for Family Medicine.

We believe to discontinue support for residency training in family medicine will have serious negative effects on family practice and primary health care in the Province of Nova Scotia. The presence of the residency program has been a stimulus for the Department of Family Medicine to develop as a Centre for education development and research in family practice for the Maritimes.

To discontinue this support for residency training will have a negative effect on the numbers of high quality family practitioners entering practice in the Maritimes and in Nova Scotia particularly. (To date 26 graduates of other Canadian medical schools have been attracted through the residency program to the Maritimes and have initiated practice here).

A reduction in the number of residency positions would have a consequent effect on the number of teaching practices in the Department and thus the number of faculty. As these faculty members are involved in numerous other activities related to primary health care ranging from teaching (medical students, nursing students, pharmacy students, health records students); geriatric health care planning; home care; research development; computer application in practice; and other developments of primary care, the effects would be far reaching.

The high quality faculty will resign and move elsewhere where teaching family practice is given appropriate support and encouragement. The support for the Department of Family Medicine by New Brunswick demands that increasing numbers of residents be assigned to that province for clinical experience which will reduce various patient services provided by residents in Nova Scotia and will reduce residents' exposure to Nova Scotia as a likely place to practice. (The New Brunswick Department of Health has indicated its intent to support a substantial number of salaries for Family Medicine residents).

The strength of the Family Medicine base in the Dalhousie Medical Faculty and its subsequent influence on the undergraduate medical curriculum will be diminished. The major centre for academic growth and development for family practice in the Maritimes will be eroded. The Department, as a political base of family practice in Halifax, has played a significant role in the development of Departments of Family Medicine at the Grace, the Infirmary, and Camp Hill Hospitals. The support of the Department has been actively given to the General Practice Section of the Medical Society of Nova Scotia, the College of Family Physicians and the Halifax General Practitioners' Society.

The national and international perception of this province's lack of support for Family Practice Training has already been reported from as far as Vancouver, the United Kingdom and Australia. Quality Canadian practitioners from other schools, or Dalhousie graduates who have taken postgraduate training elsewhere, will be reluctant to consider a career in family practice in this Province.

We therefore recommend that the Department of Health re-establish its support for Family Medicine Residency Training by re-establishing its funding base for residents in Family Medicine.

There is little cost currently for Family Medicine Training to the Department of Health other than the salaries for Family Medicine Interns and Residents. Dalhousie University currently is contributing just under $500,000 to the clinical operation of the Family Medicine Centres. This is distinctly different from other provinces supporting family practice residents where Departments of Health fund the clinical operations of such teaching units by attaching them administratively and sometimes physically to hospitals.

We would therefore recommend that the Department of Health establish its further support for family medicine residency training by accepting the cost of the operation for the clinical facilities of the Family Medicine Centres as a hospital-based budget item, with one or other or both of the more community based adult hospitals in Halifax, similar to other provinces.

II HOME CARE

There is a great need for improved health care services at the Home Care level in Nova Scotia. Home Care is not recognized as a vital component of primary health care services. Even when hospital beds have been closed, no meaningful attempt has been made to bolster community resources to meet the increased demands of caring for sick people at home. This is of particular concern in the Halifax metro area where the bed-to-population ratio for non-tertiary care problems places tremendous pressure on families, on family practices, on community nursing services and community resources generally.

Nova Scotia is one of the few provinces where community home care services are not coordinated. Individual community agencies are struggling to provide services with much fragmentation and duplication.

Most of the costs of home care are borne directly by patients and their families as compared to the costs of patients who are in hospitals and nursing homes, subsidized by public funding through government. This financial inequality creates barriers to home care and encourages hospitalization.

Agencies providing direct patient services (e.g., VON, physiotherapy) are prevented from developing their full capabilities by a lack of financial support. Even though scaled to means tesing, their "user pay" system is a deterrent to patients and to family doctors who might otherwise refer patients to them.

We recommend that the Department of Health take the leadership in developing a universal Home Care Program in this province, applying it initially in those areas where the actual bed/population ratios indicate drastically reduced

availability of hospital beds. We encourage co-operative liaising between relevant government departments and private community agencies to ensure appropriate use of services.

III PREVENTIVE PRACTICES

Studies by Curry et al[1], on the actual activities of Maritime family doctors and other North American studies confirm that a substantial amount of the family doctors' office work currently is related to preventive practices including high risk disease screening examination, well-baby examinations, well-woman examinations (including Pap Smears), anti-smoking education and immunizations. Stewart, in a recent study of Maritime family doctors,[2] has demonstrated that most offer counselling of a preventive nature during visits for other reasons with measurable, though limited, success despite inappropriate recompense for such activity. To demonstrate effective prevention cooperative pilot efforts and research are needed in this province which permit allied health professionals to carry greater responsibility, recognizing that one's personal physician has a considerable impact on influencing life style improvements.

Current cooperative approaches to avoid problems in people at risk include Community Health Nurse visiting. Visits of nurses to schools have been demonstrated to be useful in screening for vision and hearing problems, scoliosis, and interruption of communicable disease cycles. Cooperative functioning of these individuals by specific attachments of such nurses with family physicians in various parts of the province has demonstrated much success with visits to the elderly and others of high risk.

An example of other areas requiring more cooperative effort, lies in nutrition - (an estimated 1,613,000 Canadian adults are very overweight, almost 2 million children and teens get insufficient calcium[3]). Nutritional assessment is not a skill well mastered in medical school,

thus family doctors need heightened awareness in this area, requiring cooperative approaches with nutritionists.

Preventive efforts in ambulatory health care require cooperative efforts between family physicians and allied health professionals, and we recommend a refocussing of Department of Health efforts towards providing such programs for allied health professionals integrated with family physician care. An example would be attachments of community health nurses to family practices.

References

1. Curry, L., McIntyre, K. The Content of Family Practice. Do We Need More Studies? Canadian Family Physician 1982, Vol. 28, p. 124-26.

2. Stewart, Moira. Facotrs Affecting Patients' Compliance With Doctors' Advice. Canadian Family Physician 1982, Vol. 28, p. 1519-1526.

3. Sabry, Z.I., Campbell, J.A., Campbell, M.E., Forbes, A.L. Nutrition Canada. Nutrition Today, Vol. 9, No. 1. Jan.-Feb. 1974. pp. 5-13.

IV AVAILABILITY AND CONTINUITY OF SERVICES

Three trends are of grave concern to us in the manner by which primary care services are being made available to patients: the increasing use of Emergency Rooms as primary care facilities for non-emergent problems; the reduced involvement of family practitioners in hospital care; and the threat of deputized on-call services which are separate and distinct from the existing doctor groups' sign-out arrangements (an arrangement currently functioning in other countries and provinces).

a) Emergency Rooms

Especially in the Halifax-Dartmouth area, Emergency Rooms have become a source of considerable primary care with relatively little resistance. For problems which are non-emergent, we feel this is a costly way of providing care and the overall care in terms of follow-up and communication with the patient's family doctor is often far less than ideal. The recent developments of the College of Family Physicians and the Royal College of Physicians and Surgeons Training Programs in Emergency Medicine have been a realistic approach to an increasing demand but sincere attempts to reverse the trend have clearly not been made.

In communities where Emergency Room coverage is not linked with on-call systems, studies should be made with appropriate recommendations looking at:

1) The effectiveness of communication between the patient's family doctor and covering doctors in Emergency Rooms.
2) The extent to which physicians are "signing out" to Emergency Room departments.

3) the cost-effectiveness of providing incentives within the MSI fee schedule for patients to be seen in private offices (rather than emergency rooms of hospitals) after hours.

b) In-hospital Care by Family Doctors

Insufficient involvement of family doctors in the hospital care of their patients has been a continuing problem particularly in Halifax teaching hospitals. There are now four departments of Family Practice associated with these hospitals and a small number of adult beds are available to members of the active family practice staff (a small minority of the Metro practitioners). The Grace Hospital and the IWK Children's Hospital allow family doctors with courtesy privileges to admit patients.

These departments, and the small in-patient units, provide teaching as well as patient care and have been active in liaison with allied health personnel. It is hoped that community practitioners will become increasingly involved in hospital activities and that the day of the family doctor practising entirely out of his/her office will be a thing of the past. We recommend that the Halifax hospitals continue to develop ways of involving family physicians in hospital care.

c) On-call Services

In other countries, particularly the United Kingdom and Australia, and to some extent, in some cities of central and western Canada, there are now groups of doctors who do nothing but provide after-hours coverage on a contract basis. This practice is to be condemned because it reduces the communication potential between those on-call and those providing regular hours coverage. The practitioners involved

are often hospital-based young MD's with less experience and with greater tendencies to use expensive hospital resources.

We are also concerned that the size of sign-out groups in some cases is getting too large for effective communication to be assured regarding patients seen.

We recommend that sign-out services that use other then family physicians who work regularly with each other be discouraged from developing in this Province.

V CONTINUITY OF SERVICES

There continue to be breakdowns in communication between secondary and tertiary hospital services and the patients' personal physician. This happens for practitioners in the Metro area but is particularly frustrating for those who practice outside Metro. Recent attempts by the Halifax tertiary care hospitals to improve information dispersal through a letter sent with the patient upon discharge have somewhat improved the situation and the IWK Hospital has recently reinstituted mailing Emergency Room sheets to the family doctor. Liaison and discharge-planning nurses or social workers are also contributing to smoother transfer of patients between hospital and home. We applaud these steps to improve communication. We recommend that hospitals continue to make necessary changes to improve communication with family doctors to facilitate the patients' move from community to hospital to community again. We recommend that all teaching services emphasize to clerks, interns and residents, the necessity of communicating with each patient's family doctor early in the hospital stay and again before discharge and that family doctors be consulted by the house and attending staff about significant decisions affecting their patients, whenever possible. We recommend that family doctors visiting the teaching hospitals to provide supportive care be made readily welcome by the hospital staff.

VI PARTICULAR DISCIPLINES

a) Geriatrics

We recommend that the Department of Health work closely with Dalhousie University and the family practitioners of the Province, in a coordinated fashion to develop both in-hospital and community based Geriatric services in an appropriate balance. In particular, primary care practitioners (doctors, nurses, social workers, physical and occupational therapists, chiropodists, etc.) all must be part of the planning for such services, if inappropriate use of costly hospital beds for geriatric patients is to be avoided. Geriatrics is not solely a subspecialty of internal medicine and geriatric services should be developed in a multi-disciplinary way with the full recognition that the large bulk of geriatric care will continue to be provided at a primary care level.

b) Psychiatry

There are difficulties in arranging appropriate care for acutely ill psychiatric patients who require urgent hospitalization, especially after hours and on weekends. Such patients are often complex and require coordination of medical and psychiatric management. Recent bed reductions have left the Nova Scotia Hospital operating at full or over-full capacity which makes immediate admission in an urgent situation difficult. This leaves the patient in the community under the care of the family doctor with inadequate systems of support until a bed becomes available.

Recent inadequate salary increments for salaried psychiatrists

compare unfavorably with neighboring provinces and the loss of available psychiatrists is a real possibility.

We recommend an immediate review of the effect of recent bed cutbacks on the Nova Scotia Hospital's ability to accept acutely ill psychiatric patients who require urgent hospitalization and that corrective measures be taken to accommodate appropriately the needs of such patients.

We recommend reconsideration of the increment offered salaried psychiatrists in order to prevent them moving out of this province.

c) Pediatrics

Of concern to many communities is the benefit to be derived from the services of a local pediatrician. To be overcome are the problems related to primary child health care being done by pediatricians and the resulting defensiveness of general practitioners, without appropriate discussion and planning. We believe the best use of the highly trained pediatricians' skills is as a consultant for special problems of individual patients and as a general advisor for community child health care planning and coordination. Better communication should be instituted among family practitioners, pediatricians, other child health professionals, hospital administrators, and the Department of Health, which would lead to a more effective use of pediatrics expertise in the communities. As well, pediatricians should be suitably remunerated for

community and hospital-related responsibilities in child health care planning and direction.

d) Obstetrics

The relationship between obstetricians and family doctors in this Province continues to be a cooperative and constructive one. The organization of obstetric care in the Province with a regionalized approach and efficient transport system is a model of how the professions and government can work together. Obstetrical care in Nova Scotia continues to be primarily by family doctors with well organized and available obstetrician consultation. With appropriate basic (including ambulatory) educational experience in obstetrics for new family doctors, we believe this is the appropriate and least costly pattern of care to continue.

e) Occupational Health

Family physicians working with trained occupational health nurses currently provide most of the worker health care in the Province of Nova Scotia. This will continue in the next 20 years despite the new specialty training program for occupational health physicians through the Royal College. Such individuals should be involved in teaching, research and long range planning. Teaching of this subject to medical students and postgraduate residents in family medicine needs to be expanded to include the specific health hazards of such industries as offshore oil, fishing, coal-mining, steel and farming.